North Carolina Department of Health and Human Services
Voluntary Shared Leave

Voluntary Shared Leave Application

Name of Recipient_____

Social Security Number_____

Division/Section _____Position Title_____

Leave requested for Employee ☐ Immediate Family ☐ Relationship to Employee _____

GENERAL MEDICAL CONDITION (PHYSICIAN STATEMENT ATTACHED)_____
_____
APPROXIMATE PERIOD OF PARTICIPATION IN THIS PROGRAM _____
VACATION LEAVE BALANCE _____SICK LEAVE BALANCE_____
BONUS LEAVE BALANCE _____

EMPLOYEE'S AUTHORIZATION

I, _____, HAVE REQUESTED, OR HAVE BEEN NOMINATED, TO RECEIVE LEAVE UNDER THE PROVISIONS OF THE VOLUNTARY SHARED LEAVE POLICY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND HEREBY AUTHORIZE THE AGENCY TO DISCLOSE MY NEED FOR DONATED LEAVE.

RECIPIENT'S SIGNATURE _____DATE_____

I request the following specific State Agencies be contacted for leave donations: _____
_____

I request the following employee(s)be contacted NAME(S):_____

_____at DEPT/AGENCY_____

HR CONTACT:_____ PHONE NUMBER_____

_____

For Human Resources Staff Use Only

AMOUNT OF LEAVE RECEIVED: VACATION_____SICK_____BONUS_____
AMOUNT OF LEAVE RETURNED: VACATION _____SICK _____BONUS_____
APPROVED ☐ NOT APPROVED ☐ SIGNATURE_____DATE_____
ACCOUNT CLOSED _____
_____

DHHS Revised 9/16/05